MAP - 22
(09/2015)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

# MEDICAID
# CHANGE OF ADDRESS

Today's Date_____

Name of person reporting address change_____

Phone number of person reporting change_____

_____
Case name (first, middle, last & suffix)

_____
(Medicaid Case Number or Social Security Number)

WHEN DID YOUR MAILING ADDRESS CHANGE _____

New Mailing Address: _____
Street Apt. #

_____
City State Zip Code

Home address if different: _____
Street Apt. #

_____ ____
City State Zip Code

I certify under the penalty of perjury, that the information given by me is true and complete to the best of my knowledge. I give my consent to make any necessary contacts to prove my statement. I understand that if I give false information or conceal information in order to get or keep medical coverage, I will be subject to criminal sanctions under federal law, state law, or both, and I may have to pay back the cost of medical care received.

You may fax this form to the Centralized Mail Center at 1-502-573-2005 or send by US postal service to: Centralized Mail PO Box 2104 Frankfort, KY 40601

Reminder: If you have additional changes to report in your household situation log into the Self-Service Portal at https://kynect.ky.gov/ or call kynect at 1-855-459-6328 or DCBS at 1-855-306-8959. You may also visit a Department for Community Based Services (DCBS) office. To find a DCBS office near you go to https://prd.chfs.ky.gov/Office_Phone/index.aspx.

_____
Signature of Medicaid member or authorized representative Date